STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155479	A. BUILDING **01, 02** B. WING _____	R **04/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON CARE CENTER OF FORT WAYNE	**1010 W WASHINGTON CENTER RD** **FORT WAYNE, IN 46825**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS	{K 000}		

A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/20/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

Survey Date: 04/17/15

Facility Number: 000522
Provider Number: 155479
AIM Number: 100267040

At this Life Safety Code survey, Kingston Care Center of Fort Wayne was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and with 410 IAC 16.2. The orginal building consisting of main entrance and the center service hall was surveyed with Chapter 19, Existing Health Care Occupancies.

This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detector in all resident rooms except resident rooms 401-405 where battery operated smoke detector have been installed. The facility has a capacity of 137 and had a census of 123 at the time of this survey.

All areas where the residents have customary access were sprinklered. The facility had a detached unsprinklered storage building providing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155479	A. BUILDING **01, 02** B. WING _____	R **04/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON CARE CENTER OF FORT WAYNE	**1010 W WASHINGTON CENTER RD** **FORT WAYNE, IN 46825**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 1 facility services which was used for the storage of mowing equipment.	{K 000}		
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/20/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/17/15 Facility Number: 000522 Provider Number: 155479 AIM Number: 100267040 At this Life Safety Code survey, Kingston Care Center of Fort Wayne was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and with 410 IAC 16.2. The new section building consisting of the 100, 200, 300 and 400 halls was surveyed with Chapter 18, New Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detector in all resident rooms except resident rooms 401-405 where battery operated smoke detector have been installed. The facility has a capacity of 137 and had a census of 123 at the time of this survey.	{K 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155479	A. BUILDING **01, 02** B. WING _____	R **04/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON CARE CENTER OF FORT WAYNE	**1010 W WASHINGTON CENTER RD** **FORT WAYNE, IN 46825**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 2 All areas where the residents have customary access were sprinklered. The facility had a detached unsprinklered storage building providing facility services which was used for the storage of mowing equipment.	{K 000}		